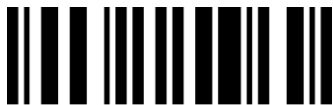


Simponi (Golimumab) Prior Authorization Request Form



5601

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Pharmacy Program (TPHarm). Express Scripts is the TPHARM contractor for DoD.

SPECIAL NOTES: Simponi, Cimzia, Enbrel, and Kineret are non-formulary (Tier 3) under the DoD Uniform Formulary and carry a higher copay for non-Active duty beneficiaries than Humira and Amevive, which are formulary (Tier 2). TRICARE does not cover Simponi for Active duty beneficiaries, who pay no co-pay, unless it is determined to be medically necessary instead of a formulary agent.

Medical necessity forms are available on the TRICARE Pharmacy website at http://pec.ha.osd.mil/forms_criteria.php. This form may NOT be used to meet medical necessity requirements. Active duty beneficiaries newly starting on Cimzia, Enbrel, Kineret, or Simponi require both forms.

MAIL ORDER and RETAIL	<ul style="list-style-type: none">The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477
	<ul style="list-style-type: none">The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at https://rxnet.army.mil/pec/forms_criteria.php. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: **Simponi (golimumab)**

Step 1 Please complete patient and physician information (Please Print)

Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
Sponsor ID#	_____	Phone #:	_____
Date of Birth:	_____	Secure Fax #:	_____

Step 2 Please complete the clinical assessment

1. Will the patient be receiving Orencia (abatacept), Humira (adalimumab), Kineret (anakinra), Cimzia (certolizumab), Enbrel (etanercept), Remicade (infliximab), or Rituxan (rituximab) in combination with Simponi?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to Question 2
2. Is Simponi being prescribed for moderate to severely active rheumatoid arthritis?	<input type="checkbox"/> Yes Please proceed to Question 3	<input type="checkbox"/> No Please proceed to question 4
3. Does the patient already have an active prescription for methotrexate?	<input type="checkbox"/> Yes Please sign and date. See quantity limits below	<input type="checkbox"/> No Coverage not approved
4. Is Simponi being prescribed for the treatment of moderate to severely active psoriatic arthritis or the treatment of active ankylosing spondylitis?	<input type="checkbox"/> Yes Please sign and date. See quantity limits below	<input type="checkbox"/> No Coverage not approved

Quantity limits: limited to a 4-week supply in retail and an 8-week supply in mail order

Step 3 I certify that the above is correct to the best of my knowledge (Please sign and date):

_____ Prescriber Signature	_____ Date
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